

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		03525		
3530														
1. PLACE OF DEATH a. COUNTY		ST. MARYS			MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MARYLAND			b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		GREAT MILLS			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		GREAT MILLS			d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL							e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ST. MARYS					
3. NAME OF DECEASED (Type or print)		First JOHN		Middle EDWARD	Last ALLGOOD	4. DATE OF DEATH		Month MARCH		Day 25	Year 1961			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
MALE		WHITE	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>		JULY 16, 1907		53 yrs.		Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
ENGINEER (RETIRED)			CIVIL SERVICE			VIRGINIA			USA					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
WRIGHT ALLGOOD					MARGARET EVANS									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address								
NO		578 10 7951		MARY E. ALLGOOD - GREAT MILLS, Md.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary occlusion										immediate				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis										2 yrs				
DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
19														
21. I certify that (I) (this hospital) attended the deceased from June 6, 1960, to March 25, 1961, that (I) (we) last saw the deceased alive on March 15, 1961, and that death occurred 7:45 AM, from the causes and on the date stated above.										22b. DATE SIGNED 3/25/61				
22a. SIGNATURE <i>P.J. Bean MD</i>					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					GREAT MILLS, MARYLAND				
P.J. BEAN, MD														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/28/61		23c. NAME OF CEMETERY OR CREMATORIUM ST. JOSEPH CEMETERY			23d. LOCATION (City, town, or county) MORGANZA, MARYLAND		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE P.B. ROBINSON		ADDRESS LEONARDTOWN, Md.		25a. REC'D BY REGISTRAR DATE MAR 30 '61			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

OCAS

ETIENNE

CHATEAU

ETIENNE

CHATEAU

CHATEAU

JASIN

JASIN

US HOUSES - CHATEAU JASIN - CHATEAU JASIN

US HOUSES - CHATEAU JASIN - CHATEAU JASIN

AIRPORT - CHATEAU JASIN - CHATEAU JASIN

CHATEAU JASIN - CHATEAU JASIN

US HOUSES - CHATEAU JASIN - CHATEAU JASIN

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

03526

1  
 PLACE OF DEATH  
 a. COUNTY

3531  
 St. Mary's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Leonardtown

c. LENGTH OF STAY IN 1b

9 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

St. Mary's Hospital

3. NAME OF  
DECEASED  
(Type or print)

First Middle

Catherine

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

e. STATE

Maryland

b. COUNTY

St. Mary's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Lexington Park

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?

YES  NO

32

4. DATE  
OF  
DEATH  
Last Month Day Year  
March 9, 1961

B. DATE OF BIRTH

May 17, 1929

9. AGE (In years  
last birthday)  
31 yrs.

IF UNDER 1 YEAR

Months Dey

IF UNDER 24 HRS.

Hours Min.

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

WIDOWED  DIVORCED

10b. KIND OF BUSINESS OR INDUSTRY  
11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Female

Colored

House work

Home

Medley's Neck Maryland

U.S.A.

13. FATHER'S NAME

Thomas Louis Barnes

Address

14. MOTHER'S MAIDEN NAME

Lucy Lillian Mason

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY NO.

17. INFORMANT

(Yes, no, or unknown)

(If yes give war or date of service)

No

Emmitt Barnes Rt 2 Box 71A Hollywood, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a)

*Carcinoma of Cervix.*

INTERVAL BETWEEN  
ONSET AND DEATH  
6-8 mo.

171X

DUE TO

Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour e.m.  
p.m.

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from June 1960, to September 1961, that (I) (we) last saw the deceased alive on September 1961, and that death occurred at M, from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S  
NAME (Type)

Ernest Rehm M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22d. ADDRESS

22b. DATE  
SIGNED

Lexington Park, Maryland

23a. BURIAL, CREMATION,  
REMOVAL (Specify)  
Burial

23b. DATE THEREOF  
3/11/61

23c. NAME OF CEMETERY OR CREMATORIAL  
ADDRESS  
Our Lady's Chapel

23d. LOCATION (City, town or county)

(State)

Medley's Neck

Md.

24 FUNERAL DIRECTOR'S SIGNATURE

W. Clarke Mattingley, Leonardtown, Maryland

25a. REC'D BY REGISTRAR  
MAR 14 '61  
DATE

25b. REGISTRAR'S SIGNATURE  
Arthur S. Kraus

100

2000 meters

1000 meters

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**3532**

**CERTIFICATE OF DEATH**

103527

1  M  X		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, II institution; Residence before admission)						
		a. COUNTY	St. Mary's MARYLAND	e. STATE	Maryland					
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	f. COUNTY	St. Mary's					
		Rural Colton Point	52 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Rural Colton Point X		e. IS RESIDENCE ON A FARM?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
		3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Dey	Year	
		Francis Eugene			Butterfield	March	22,	1961		
		5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
		Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 8, 1891	69 yrs.	Months	Deys	Hours	Mins.
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
		Guard naval proving	U.S. Government	South Carolina		U. S. A.				
		13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME							
		Francis Eugene Butterfield	Catherine Nurnburger							
		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank & dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address					
		no	none	Mary A. Butterfield	Colton Point, Maryland					
		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH			
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)	Coronary Thrombosis				1 hour			
		420.1	DUE TO							
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.	(b)	Coronary insufficiency with Bundle Branch Block				> 3 mths		
			DUE TO							
			(c)							
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED?			
		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hemorrhage				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
		20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) October 5, 1945, to March 24, 1961	(County) Leonardtown	(State) Maryland		
		21. I certify that (I) (this hospital) attended the deceased from February 21, 1961, and that death occurred at 11 P.M., from the causes and on the date stated above.					22b. DATE SIGNED 3/23/61			
		22e. SIGNATURE Robert Fuchs	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>				
		22c. PHYSICIAN'S NAME (Type) Robert Fuchs M. D.	22d. ADDRESS Leonardtown, Maryland							
		23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE THEREOF 3/24/61	23c. NAME OF CEMETERY OR CREMATORIAL All Saints	23d. LOCATION (City, town or county) Oakley, Maryland		(State)			
		24 FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley	ADDRESS Leonardtown, Maryland	25a. REC'D BY REGISTRAR DATE MAR 24 '61		25b. REGISTRAR'S SIGNATURE Class 18 hours				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 days may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

662

M

Major station, future

WTC

2000' and less, local

Major station, future, 1000' and more, non-Public Interest radio

Major station, future, 1000' and more, commercial

Minor station, nightshift, local

local

Minor station, nightshift

non-public interest

Minor station, nightshift, public interest, 1000'

Minor station, nightshift, public interest, 1000'

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. If 24 hours are required, the physician or hospital may be retained by the attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**3533**

Items 8 & 9 film G283

**CERTIFICATE OF DEATH**

3/20/61 iwk

03528

**1. PLACE OF DEATH**

a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Leonardtown

c. LENGTH OF STAY IN 1b

18 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

St. Mary's Hospital

**3. NAME OF  
DECEASED  
(Type or print)**

First  
Ida

Middle  
Irene

Last  
Countiss

**4. DATE  
OF  
DEATH**

Month  
March

Dey  
10,

Year  
19 61

**5. SEX**

6. COLOR OR RACE

Female

Colored

7. MARRIED  NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Oct. 9, 1913

9. AGE (In years  
less birthday) IF UNDER 1 YEAR

47 yrs.  
Months

IF UNDER 24 HRS.

Days  
Hours  
Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

**13. FATHER'S NAME**

John S. Woodland

14. MOTHER'S MAIDEN NAME

Mary Alice Kay

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

none

Henry W. Countiss Charlotte Hall, Maryland

**18. CAUSE OF DEATH** [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (e)

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Carcinoma of colon with  
metastasis

INTERVAL BETWEEN  
ONSET AND DEATH

2 yrs

**MEDICAL CERTIFICATION**

2Da. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. While at work  Not While at work   
p.m. 19

2Dd. INJURY OCCURRED  
While at work  Not While at work

2De. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

2Df. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 1958, 19....., to Mar. 10, 1961, that (I) (we) last saw the deceased alive on Mar. 10, 1961, and that death occurred at.....M, from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S  
NAME (Type)

M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22b. DATE  
SIGNED

22d. ADDRESS

Mechanicsville, Maryland

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

23b. DATE THEREOF

3/13/61

23c. NAME OF CEMETERY OR CREMATORI

St. Joseph

23d. LOCATION (City, town or county)

(State)

Morganza, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

W. Clarke Mattingley Leonardtown, Maryland

25e. REC'D BY REGISTRAR

MAR 14 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

333

1946-1947

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3534

## CERTIFICATE OF DEATH

03529

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. If 24 hours are not available, the physician or attending physician may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

BP

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>6 day's</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>		e. COUNTY <b>Rural Drayden</b>	
3. NAME OF DECEASED (Type or print) <b>William Henry Goodwin</b>		4. DATE OF DEATH Month Day Year <b>March 3, 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 8, 1898</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William U. Goodwin</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ellen Wood</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Mrs Mary Eva Goodwin Drayden, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> <i>Central occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 10, 1959</b> , to <b>March 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 2, 1961</b> , and that death occurred at <b>12:30 AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>J.P. Bean M.D.</b>	
22c. PHYSICIAN'S NAME (Type) <b>J.P. Bean M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Great Mills, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/6/16</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>St. George Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Valley Lee, Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 7 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>	

857



1

1  
FOR STATE  
HEALTH DEPT.

M

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03530

1. PLACE OF DEATH  
a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chesapeake Bay,  $\frac{1}{4}$  Mile

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

South of Boat House #2, NAS Patuxent

3. NAME OF  
DECEASED  
River, Maryland  
(Type or print)

William Elmer

Middle

5. SEX

Male CAUC

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Pilot

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Navy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or grade of service)

Yes

16. SOCIAL SECURITY NO.

17. INFORMANT

Present

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

INJURIES, MULTIPLE, EXTREME (8651)

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate

866X  
Conditions, if any, which  
give rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

(b)

Air Craft Accident

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES  NO

20e. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Aircraft accident - Only about 15 lbs of body recovered

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.

1127 XX 3-17 1961

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

Chesapeake Bay Lexington Park, St. Mary's Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

3-18-61

ACTUAL  
SIGNATURE

Wm. D. BOYD Leonardtown, Md., M.D.

EXAMINER'S  
NAME (Type)

Edmund Perry JACOB MC USN, USNAS (PATUXENT RIVER, MARYLAND)

22e. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

Removal 3/21/61

23. FUNERAL DIRECTOR

S. B. Robinson - Leonardtown, Md.

ADDRESS

22d. LOCATION (City, town, or country)

(State)

Catawissa, Pennsylvania

24e. REC'D BY REGISTRAR

MAR 23 '61

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Trahan

WASH TO THOUSANDS OF 37X72 QUILTS  
MADE BY WOMEN IN THE COUNTRY AND  
SHIPPED TO ESTABLISHED RETAILERS. ALL  
CLOTHES ARE  
100% COTTON.

100% COTTON  
100% COTTON

X  
100% COTTON, 100% COTTON, 100% COTTON  
100% COTTON, 100% COTTON, 100% COTTON

10 71 100% COTTON, 100% COTTON, 100% COTTON

10 71 100% COTTON, 100% COTTON, 100% COTTON

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be signed by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Items 8 & 9 Film G284 4/12/61 iwk											
CERTIFICATE OF DEATH											
Reg. Dist. No. 04759											
1. PLACE OF DEATH o. COUNTY <b>St. Mary's MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Pennsylvania</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River</b>			c. LENGTH OF STAY IN lb <b>11 days</b>			b. COUNTY <b>Philadelphia</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Philadelphia</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Station Hospital, USNAS, Pax Riv. Md</b>						d. STREET ADDRESS <b>4316 Walnut Street</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First <b>Francis</b>	Middle <b>James</b>	Lost <b>HAGER</b>	4. DATE OF DEATH <b>March 10 1961</b>	Month <b>March</b>	Day <b>10</b>	Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-20-02 1908</b>	9. AGE (In years lost birthday) <b>52 58 yrs.</b>	IF UNDER 1 YEAR Months <b>52</b>	IF UNDER 24 HRS. Days <b>58</b>	Hours <b>00</b>	Min. <b>00</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>			11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Joseph Michael HAGER</b>						14. MOTHER'S MAIDEN NAME <b>Bridget MORRIS</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>160 05 2463</b>		INFORMANT <b>Catherine Patricia WILLIG</b>		Address 619 So. Line St. Lancaster, Penna					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cessation of heart beat</b> INTERVAL BETWEEN ONSET AND DEATH <b>None</b>											
331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) Increased intracranial pressure 24 hours											
DUE TO (c) Cerebral Hemorrhage 24 hours											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? IF EITHER, NOTIFY MEDICAL EXAMINER YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>9 March 1961</b> , to <b>10 March 1961</b> , that I last saw the deceased alive on <b>10 March 1961</b> , and that death occurred at <b>6:20 P.M.</b> from the causes and on the date stated above.											
ADDRESS (Street, city or town, state) DATE SIGNED <b>Station Hospital</b> 10 March 61											
ACTUAL SIGNATURE <i>Clarence W. Rawson Jr.</i>											
PHYSICIAN'S NAME (Type) <b>Clarence W. Rawson, Jr. U.S. Naval Air Station, Patuxent River, Md</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		22b. DATE THEREOF <b>3-14-61</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) <b>Philadelphia</b>		(State) <b>Pa.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey Funeral Home, Bethesda, Md.</b>						24a. REC'D BY REGISTRAR <b>Arthur S. Thomas</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



FOR STATE  
HEALTH DEPT.

Please initial if a copy is necessary,  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME  
5M 7/59

To DEATH: Please initial if a copy is necessary.  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**3537 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** (13531)

1. PLACE OF DEATH a. COUNTY		St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Lexington Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Lexington Park	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		107 Chinlee Drive		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last		4. DATE OF DEATH	Month Day Year
Henry		Jacob	HANSEN	107 Chinlee Drive		March 2	19 61
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		Caucasian		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10-30-30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
Sailor		U. S. Navy		New York		30 yrs.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
Jacob Henry HANSEN		Clara BRUTO		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			
Yes 2/48 - 3-2-61		081 32 1571		Official U. S. Naval Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Electric Shock (8708)		INTERVAL BETWEEN ONSET AND DEATH Immediate	
914		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		Dismanteling T.V.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:40 <del>xx</del> 3-2- 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Home Lexington Park St. Mary's Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE J. H. ARMSTRONG, LT MC USNR		CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER		DATE SIGNED			
EXAMINER'S NAME (Type) Wm. D. BOYD, M.D. LEONARDTOWN, MD.		DEPUTY MEDICAL EXAMINER					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/61		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR P.B. Johnson		ADDRESS		24a. REC'D BY REGISTRAR MAR 7 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hause	
				DATE			

X *W. Smith* *W. F.* *W. F.*

*W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

*W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

*W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

*W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

*W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

X *W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

*W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

*W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

X *W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

*W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

*W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

*W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

*W. F.* *W. F.* *W. F.* *W. F.* *W. F.*

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3538

03532

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death, if 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

078

1. PLACE OF DEATH  
a. COUNTY

St. Mary's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Leonardtown

4 days

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

St. Mary's Hospital

3. NAME OF  
DECEASED  
(Type or print)

First Middle

James

Carroll

Kredell

## 5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

WIDOWED  DIVORCED 

Jan. 17, 1921

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electronics Mechanic

10b. KIND OF BUSINESS OR INDUSTRY

Civil Service

11. BIRTHPLACE (County &amp; State, or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

J. Allmann Kredell

## 14. MOTHER'S MAIDEN NAME

Anne M. Carroll

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

Yes

WW II

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs Elizabeth T. Kredell

Same as # 2

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

163X

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Pulmonary Failure -  
Carcinomatosis  
Carcinoma of the right lungINTERVAL BETWEEN  
ONSET AND DEATH

1 1/2 year

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m.  
p.m.20d. INJURY OCCURRED  
While at work  Not While at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19 21

21. I certify that (I) (this hospital) attended the deceased from January, 1961 to March 18, 1961, that (I) (we) last saw the deceased alive on 3/19/1961, and that death occurred at 6 AM, from the causes and on the date stated above.

## 22a. SIGNATURE

A. Samad  
A. SAMAD, M.D.

M.D.

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS. 22b. DATE  
SIGNED22c. PHYSICIAN'S  
NAME (Type)

## 22d. ADDRESS

NEONARD TOWN Md.

23a. BURIAL, CREMATION  
REMOVAL (Specify)  
Burial23b. DATE THEREOF  
3/21/61

## 23c. NAME OF CEMETERY OR CREMATORIUM

St. Mary's

## 23d. LOCATION (City, town or county)

Pittsburgh,

(State)

Pa.

## 24 FUNERAL DIRECTOR'S SIGNATURE

W. Clarke Mattingley

## ADDRESS

Leonardtown, Maryland

## 25a. REC'D BY REGISTRAR

DATE MAR 20 '61

## 25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

226

M

DATA:

ESTADO CÍNSIO

TRIB. MUNICIPAL DE

DEPARTAMENTO

ART. 51

ART. 52

ART. 53

ART. 54

ART. 55

ART. 56

ART. 57

ART. 58

ART. 59

ART. 60

ART. 61

ART. 62

ART. 63

ART. 64

ART. 65

ART. 66

NOTAS

DETALHES

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it may be retained by the hospital or attending physician. If either, notify medical examiner.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3539

## CERTIFICATE OF DEATH

03533

1. PLACE OF DEATH e. COUNTY <b>St. Mary's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE <b>Maryland</b>		b. COUNTY <b>St. Mary's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Leonardtown</b>		d. STREET ADDRESS <b>I</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Joseph</b>		First	Middle	Last	4. DATE OF DEATH <b>March 6, 1961</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 4, 1869</b>	9. AGE (In years last birthday) <b>91 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James Henry Mattingly</b>		14. MOTHER'S MAIDEN NAME <b>Ann Sophia Abell</b>		Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>215-38-3986 J. Maguire Mattingly</b>		Leonardtown, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e.) <b>4222</b>		DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH		
				<i>Acute dilation of Heart</i> <i>Chronic myocarditis</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>319/61</b>	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 12, 1956</b> to <b>March 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 6, 1961</b> , and that death occurred at <b>103°</b> , from the causes and on the date stated above.								
22a. SIGNATURE <i>Charles Greenwell</i>		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>3/19/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles Greenwell M.D.</b>		22d. ADDRESS <b>Leonardtown, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/9/61</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Our Lady's Chapel</b>	23d. LOCATION (City, town or county) <b>Medley's Neck, Maryland</b>		(State)		
24 FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingly</b>		ADDRESS <b>Leonardtown, Maryland</b>		25e. REC'D BY REGISTRAR <b>DATE MAR 13 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Turner</i>		



1

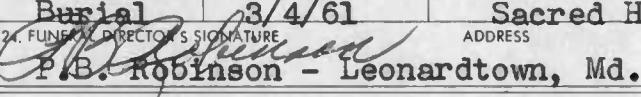
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3540

13534

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Abell</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Abell</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		e. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) <b>Esther Lorraine Owens</b>		First <b>Esther</b>	Middle <b>Lorraine</b>
4. DATE OF DEATH <b>March 1, 1961</b>	Month <b>March</b>	Day <b>1</b>	Year <b>1961</b>
S. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/27/1910</b>
9. AGE (In years last birthday) <b>50 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Arthur B. Lawrence</b>	14. MOTHER'S MAIDEN NAME <b>Florence Morris</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>220 32 6131</b>	17. INFORMANT <b>Charles L. Owens - Abell, Maryland</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO  (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 1960</b> to <b>March 1, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb 27 1961</b> , and that death occurred <b>7:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE 	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>3/2/61</b>
22c. PHYSICIAN'S NAME (Type) <b>Wm. D. Boyd, MD</b>	22d. ADDRESS <b>Leonardtown, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/4/61</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Sacred Heart Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Bushwood, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS <b>P.B. Robinson - Leonardtown, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>MAR 7 '61</b>
			25b. REGISTRAR'S SIGNATURE 



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. If more than 24 hours elapse, the physician or attending physician must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**3541**

**03535**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mattie Wells Quirk</b>		First      Middle      Last	4. DATE OF DEATH      Month      Day      Year <b>March 18, 1961</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Jan. 10, 1886</b>		9. AGE (In years last birthday)      IF UNDER 1 YEAR      IF UNDER 24 HRS. <b>75 yrs.</b> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Dean H. Dawson</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Purcell</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES?      16. SOCIAL SECURITY NO.      17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address <b>George R. Quirk Park Hall, Maryland</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>092X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <b>Hepatitis</b>	
		DUE TO <b>Virus Hepatitis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Coronary Insufficiency</b>	
20c. TIME OF INJURY      Month, Day, Year Hour a.m.      p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)      (County)      (State) <b>Washington, D.C.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 11, 1945</b> , to <b>March 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 17, 1961</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>3/21/61</b>	
22e. SIGNATURE <b>Robert F. Fuchs</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.	22d. ADDRESS <b>Leonardtown, Maryland</b>
22c. PHYSICIAN'S NAME (Type) <b>Robert Fuchs M. D.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombed</b>	
23b. DATE THEREOF <b>3/21/61</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Later Ebenezer</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>		23d. LOCATION (City, town or county) (State) <b>Great Mills, Maryland</b>	
		25a. REC'D BY REGISTRAR <b>MAR 23 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Tamm</b>	

100

Highway traffic. 2000 s. information

Indicates 1000 s.

Highway traffic. 2000 s. information

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. If it is necessary to retain the certificate by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF MEDICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

03536

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Compton</b>		b. COUNTY <b>St. Mary's</b>	
c. LENGTH OF STAY IN 1b <b>10 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Compton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Donald W. Shannon</b>		First	Middle
Last		4. DATE OF DEATH <b>March 2, 1961</b>	Month Day Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Nov. 1, 1900</b>		9. AGE (in years last birthday) <b>60 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Government</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>	11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>William Shannon</b>	
14. MOTHER'S MAIDEN NAME <b>Beatrice McNalley</b>		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs Dorothy M.C. Shannon</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> DUE TO <b>(c)</b>	
19. WAS AUTOPSY PERFORMED? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		INTERVAL BETWEEN ONSET AND DEATH <b>immed</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Leonardtown</b>	(County) <b>Maryland</b>	(State) <b>MD</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1960</b> , to <b>March 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 1, 1961</b> , and that death occurred at <b>10A.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>3/3/61</b>	
22a. SIGNATURE <b>W.D. Boyd</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>William D. Boyd M.D.</b>		22d. ADDRESS <b>Leonardtown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/6/61</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Forest Glen Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Forest Glen, Maryland</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>		ADDRESS	25a. REC'D BY REGISTRAR DATE <b>MAR 7 '61</b>
			25b. REGISTRAR'S SIGNATURE <b>Arthur J. Kline</b>

RCC



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**3543**

**CERTIFICATE OF DEATH**

**135537**

1. PLACE OF DEATH e. COUNTY <b>St. Mary's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Callaway</b>		c. LENGTH OF STAY IN lb <b>10 yrs</b>		a. STATE <b>Maryland</b>		b. COUNTY <b>St. Mary's</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Callaways</b>		d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)		First <b>Otho</b>	Middle <b>Oham</b>	Last <b>Smith</b>	4. DATE OF DEATH Month <b>March</b>	Day <b>31</b>	Year <b>1961</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1901</b>		9. AGE (In years last birthday) <b>59 yrs.</b>	IF UNDER 1 YEAR Months <b>59</b>	IF UNDER 24 HRS. Hours <b>59</b>	IF UNDER 24 HRS. Minutes <b>59</b>		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY <b>Cook</b>		11c. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>John Smith</b>		14. MOTHER'S MAIDEN NAME ? ? ?									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-16-4892</b>		17. INFORMANT <b>Robert L. Smith. Callaway, Md.</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		<i>Myocardial Infarction</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<i>Coronary Artery Disease</i>									
DUE TO (c)		<i>Atherosclerotic cardiovascular D.</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		years years									
20e. MEDICAL CERTIFICATION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
21. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>3/2, 1961</u> to <u>3/3, 1961</u> , that <u>(1)</u> (we) last saw the deceased alive on <u>3/31, 1961</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.											
22e. SIGNATURE <i>James P. Jarboe</i>		22b. DATE SIGNED <i>3/31/61</i>									
22c. PHYSICIAN'S NAME (Type) <b>James P. Jarboe, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/3/1961</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Mark</b>		23d. LOCATION (City, town or county) <b>Valley Lee</b>		(State) <b>Maryland</b>			
24 FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley, Leonardtown, Maryland</b>		25e. REC'D BY REGISTRAR DATE APR 7 '61							25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

1000

ON 1000